A. General Prior Authorization Guidelines

Providers must have prior authorization (PA) for certain specified services before delivery of that service, unless the service is provided on an emergency basis.

A summary of PA polices and guidelines for specific covered services are in Appendices 9 through 19 of this handbook.

Wisconsin Medicaid will not reimburse for the following:

- Services provided prior to the grant date indicated on the Prior Authorization Dental Request Form (PA/DRF).
- Services provided after the expiration date indicated on the PA/DRF.
- Services rendered without first obtaining PA. The provider is responsible for the cost of these services.

Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other Wisconsin Medicaid requirements, must be met prior to payment of the claim. Providers are advised that PA does not guarantee payment.

Emergency Services

Emergency dental care is immediate service that must be provided to relieve the recipient from pain, an acute infection, swelling, trismus, fever, or trauma.

PA is not required in emergency situations.

Wisconsin Medicaid waives the PA requirement for hospital calls, general anesthesia, and IV sedation. These procedures are the only procedures for which PA is waived in an emergency.

Certain services are covered only when they are provided under emergency circumstances. Refer to Appendices 9 through 19 of this handbook for more information.

The recipient's records must include documentation of the nature of the emergency. Emergency services are exempt from copayment.

Traumatic Loss of Teeth for Children Under Age 21

When a child experiences a traumatic loss of teeth, removable prostheses may be provided by backdating a PA request. Refer to Appendix 14 of this handbook for more information.

B. Prior Authorization Request Form

The PA/DRF and the Prior Authorization Dental Attachment (PA/DA) are required for PA requests. Sample forms and instructions are given in Appendices 20 through 23 of this handbook.

B. Prior Authorization Request Form (continued)

Both the PA/DRF and PA/DA must be completed and submitted to:

Prior Authorization Unit, Suite 88
EDS
6406 Bridge Road
Madison, WI 53784-0088

PA forms may be obtained by submitting a written request to:

Wisconsin Medicaid Claim Reorder
EDS
6406 Bridge Road
Madison, WI 53784-0003

Please be specific when identifying the forms requested and the quantity needed. Reorder forms are included in the mailing of each request for forms. Please do not telephone the Correspondence Unit to request forms.

Sample Prior Authorization Forms

Refer to Appendices 20 through 23 of this handbook for sample PA forms and instructions.

Prior Authorization Number

A preprinted seven-digit PA number appears in red at the top of the PA/DRF form. This is a very important number for billing as it identifies the service on the claim form as a service that has been prior authorized.

Re-Authorization of a Prior Authorization to a New Provider Number

Sometimes another dentist has already received PA for the service you are requesting. A PA may be re-authorized to your provider number if:

- You receive the following message in response to your PA request: *"A current authorization for this service is on file for another provider. If the service was not provided, a statement of that fact is required."*
- The recipient has not received the service from the initial provider and does not expect to.

To re-authorize a PA:

- Obtain a signed written statement from the Wisconsin Medicaid recipient or the originally authorized provider that the services were not received from the initial provider.
- Submit the recipient or originally authorized provider statement, along with the PA request and a brief statement about the situation, to the Wisconsin Medicaid fiscal agent.

B. Prior Authorization Request Form (continued)

The fiscal agent will contact the initial provider to terminate the existing PA and to allow you to obtain a new PA.

Refer to Section VIII of Part A, the all-provider handbook, for more information on re-authorizing PAs.

Supporting Material Requirements

In certain instances, supporting material (in addition to the request form) is required to document the need for services (such as specific x-rays). Supporting material requirements are detailed in this section and in Appendix 24 of this handbook. The Medicaid program dental consultant may request additional documentation if necessary to substantiate a PA request.

When providers submit supporting material, the material must be clearly labeled, identified, and securely packaged. Wisconsin Medicaid does not reimburse for charges for duplication of materials (e.g., copies of x-rays, study models). All materials are returned to the provider in the condition they are received.

If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider and any new materials must be provided at the provider's expense.

C. HealthCheck "Other Services"

A PA request for HealthCheck "Other Services" must include a copy of a signed HealthCheck verification card, statement, or other indication that the recipient received a HealthCheck screen. The statement or other indication must be signed by the provider who performed the HealthCheck, and it must indicate the date of the screen. The screen must be performed within one year of the date of receipt of the PA request.

Additional information documenting the individual's need for the service and the appropriateness of the service being delivered may be requested by the BHCF dental consultant.

Refer to Sections II-D and II-E of this handbook for further information on HealthCheck "Other Services."

A. Coordination of Benefits

Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under other health insurance (including Medicare), Wisconsin Medicaid pays that portion of the allowable cost remaining after exhausting all other health insurance sources. Refer to Section IX of Part A, the all-provider handbook, for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

Other Insurance Billing Information - Paper Claims

Refer to Appendices 26 through 29 of this handbook for American Dental Association (ADA) claim form and HCFA 1500 claim form completion instructions and samples.

Note: When a claim is submitted to commercial insurance and the commercial insurance pays on some of the services, and denies payment on some of the services, two separate claim forms must be submitted to Wisconsin Medicaid (so the correct reimbursement is made) by processing a claim for the partially paid services separately from the services denied by "other insurance."

Claim Showing Health Insurance Payment Made

- Submit a claim form with the services the health insurance allowed and reimbursed.
- Enter OI-P in element 15A of the ADA claim form or in element 9 of the HCFA 1500 claim form, and enter the amount paid by the health insurance in element 42 of the ADA claim form or in element 29 of the HCFA 1500 claim form.

Claim Showing Health Insurance Denied Payment

- Submit a claim form with the services the health insurance denied and did not reimburse.
- Enter OI-D in element 15A of the ADA claim form or in element 9 of the HCFA 1500 claim form.

Electronic claims use different fields to indicate other health insurance billing. Refer to your electronic media claims (EMC) manual for more information.

Refer to Part A, the all-provider handbook, for more detailed information on services requiring health insurance billing exceptions and the insurance explanation codes.

Note: When a recipient's Medicaid identification card indicates DEN (dental insurance) under "Other Coverage," all dental services must be billed to the dental insurance prior to submitting a claim to Wisconsin Medicaid.

B. Medicare/ Medicaid Dual Entitlement

Recipients covered under both Medicare and Medicaid are referred to as dual entitlees. Claims for Medicare-covered services provided to dual entitlees must be billed to Medicare prior to billing Medicaid if Medicare usually pays for the service, such as oral surgery. Wisconsin Medicaid pays the allowable coinsurance on Medicare-allowed items and any deductible that is applied to those Medicare allowed items in s. 49.46(2)(c), Wis.

B. Medicare/ Medicaid Dual Entitlement (continued)

Stats. Refer to Appendix 17 of Part A, the all-provider handbook, for specific information on Medicare/Medicaid dual entitlement. Appendix 16 of Part A, the all-provider handbook, identifies services not covered by Medicare.

C. Medicare QMB-Only

Qualified Medicare Beneficiary-only (QMB-only) recipients are only eligible for Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. (Because Medicare only covers a few dental services, most services provided for QMB-only recipients are not covered by Wisconsin Medicaid.)

D. Billed Amounts

Providers must bill Wisconsin Medicaid their usual and customary charge for services provided, which is the amount charged by the provider for the same service when provided to private pay patients. For providers using a sliding fee scale for specific services, "usual and customary" means the median of the individual provider's charge for the service when provided to non-Medicaid patients. Providers may not discriminate against Medicaid recipients by charging a higher fee for the service than is charged to a private pay patient.

The billed amount should not be reduced by the amount of Wisconsin Medicaid recipient copayment. The applicable copayment will automatically be deducted from the payment allowed by Wisconsin Medicaid. Refer to Section I of this handbook for general information about dental service copayments.

A Wisconsin Medicaid Dental Maximum Allowable Fee Schedule is available. The fee schedule consists of the dental procedure code, a prior authorization (PA) indicator, a brief narrative description, the maximum fee, and the copayment amount associated with the service.

Copies of the Wisconsin Medicaid Dental Maximum Allowable Fee Schedule may be purchased by submitting the order form located in Appendix 38 of Part A, the all-provider handbook.

E. Modifiers

Tooth Numbers and Letters

Wisconsin Medicaid recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" through "32" for permanent teeth. Wisconsin Medicaid also recognizes "SN" (super numerary) for teeth that cannot be classified under "A" through "T" or "1" through "32". Whenever a procedure applies to a specific tooth, these modifiers must be used in element 37 of the ADA claim form.

Denture Repair Modifiers

When billing the denture repair procedure codes, providers must indicate which denture is being repaired. Use the procedure code modifier "UU" for upper and "LL" for lower denture in element 37 of the ADA claim form.

Surgery Modifiers

Oral surgeons and oral pathologists billing *Physicians' Current Procedural Technology* (CPT) codes for oral surgeries must use modifier 80 in element 24D of the HCFA 1500

E. Modifiers (continued)

claim form to designate when a provider assists at surgery. Refer to the CPT code chart in Appendix 19 of this handbook to identify the services that allow assistance at surgery. Refer to Appendix 16 of this handbook for information on assisting at surgery using the ADA Current Dental Terminology (CDT) codes.

Only specific modifiers which are appropriate to the procedure billed are accepted by Wisconsin Medicaid. Claim details with modifiers which Wisconsin Medicaid has not designated as allowable are denied.

F. Place-of-Service Codes

Wisconsin Medicaid uses place-of-service codes to indicate where the service was provided. Many dental procedure codes have place-of-service restrictions. Below is a list of place-of-service codes and their descriptions:

Place of Service (POS) Description	HCFA POS
Other	0
Inpatient Hospital	1
Outpatient Hospital	2
Doctor's Office	3
Home	4
NH/Extended Care Facility	7
Skilled Nursing Facility	8
Ambulatory Surgery Center	B

Refer to Appendices 8 through 19 of this handbook for information on specific place-of-service requirements.

G. Claim Form

Paper Claim Submission

American Dental Association Claim Form for CDT Billing

Dental services provided by dentists billing with ADA (CDT) codes are submitted on the ADA claim form. A sample form and completion instructions are in Appendices 26 and 27 of this handbook.

ADA claim forms are not provided by Wisconsin Medicaid or its fiscal agent. They may be obtained by contacting:

ADA Catalog Sales
211 East Chicago Avenue
Chicago, IL 60611
1-800-947-4746

G. Claim Form (continued)

HCFA 1500 Claim Form for Current Procedural Terminology Billing

Dental services provided by dentists billing with CPT codes are submitted on the HCFA 1500 claim form. When dentists provide both ADA and CPT code services to the same patient, both may be billed on the HCFA 1500 claim form, unless the ADA code requires a tooth modifier. A sample form and completion instructions are in Appendices 28 and 29 of this handbook.

The HCFA 1500 claim form is not provided by Wisconsin Medicaid or the Medicaid fiscal agent, EDS. It may be obtained from a number of forms suppliers including:

State Medical Society Services, Inc.
Post Office Box 1109
Madison, WI 53701
(608) 257-6781
1-800-362-9080

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem.

The fiscal agent also offers a product called the Reformatter. This product is designed for providers who use an IBM-compatible computer to generate ADA claims on paper. Instead of printing claim information on paper, the claim data is transmitted via modem to the fiscal agent. The fiscal agent reformats the data into the required electronic format for processing. Claims submitted through these systems have the same legal requirements as those submitted on paper and are subject to the same processing requirements as those submitted on paper.

Software for electronic submissions may be obtained free of charge. Electronic submissions have substantial advantages in reducing clerical effort and errors, reducing mailing costs and delays, and improving processing time. Additional information on alternative claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

Wisconsin Medicaid EMC Department
EDS
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

H. Emergency Services

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, fever, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, all claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line

H. Emergency Services (continued)

item for the emergency service of the ADA claim form or element 24-I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. Only the letter "E" without any additional letters is accepted. The definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

I. HealthCheck

Certain services are covered for recipients 20 years old and under when they result from a HealthCheck screening.

In addition, other medically necessary dental services which are not normally covered by Wisconsin Medicaid may be covered for children under age 21 if they have had a HealthCheck screening. These services always require prior authorization (PA).

Refer to Section II-D and II-E of this handbook for additional HealthCheck information.

Evidence that a HealthCheck screening has occurred in the past year, such as a photocopy of the recipient's current HealthCheck card, must be included with the PA request. Check the EPSDT box in element 2 of the ADA claim form or mark "H" in element 24H of the HCFA 1500 claim form if the service requires a HealthCheck screening and a HealthCheck screening has occurred. Do not attach evidence that a HealthCheck screening has occurred with the claim form. Refer to Appendices 27 and 29 of this handbook for billing instructions when a HealthCheck screening prior to dental services is required.

EMC claims use a different field to indicate a HealthCheck screen has occurred. Refer to your EMC manual for more information.

J. Recipient Loss of Eligibility During Treatment

Prior authorized services for fixed or removable prosthodontic and orthodontic treatment may be paid by Wisconsin Medicaid after the recipient becomes ineligible as long as authorized services began when the recipient was eligible, as defined below.

If a recipient becomes enrolled in a Medicaid HMO mid-treatment, the dental provider must submit orthodontia claims following the HMO extraordinary claims billing procedures. Refer to Section IX of Part A, the all-provider handbook, for instructions.

Fixed or removable prosthodontic services provided to recipients who have become ineligible mid-treatment are covered if the recipient was eligible on the date the final impressions were made. Always use the date of the final impression as the date of service when billing for prosthodontics.

Orthodontic services provided to recipients who have become ineligible mid-treatment are covered if the recipient was eligible on the date the initial orthodontic bands were placed. These orthodontic services should be submitted according to routine procedures.

K. Occupational Illness or Injury

All claims submitted which relate to an occupational illness or an injury must be clearly identified and explained. Element 30 of the ADA claim form or elements 14, 15, and 16 of the HCFA 1500 claim form must be marked "yes" and a brief narrative relating to that response must be presented in the space provided.

EMC claims use a different field to indicate occupational illness or injury. Please refer to your EMC manual for more information.

L. Copayment

Copayment Billing Procedures

Providers should bill Wisconsin Medicaid their usual and customary charges for all services rendered. Copayment amounts collected from recipients should not be deducted from charges billed to Wisconsin Medicaid, nor should these Wisconsin Medicaid copayment amounts be indicated in the "paid by other" element on claims submitted. The appropriate copayment amount is automatically deducted by the fiscal agent from payments allowed by Wisconsin Medicaid. Remittance and Status Reports from the fiscal agent reflect the automatic deduction of applicable copayment amounts.

Providers must make a reasonable attempt to collect copayment from a Medicaid recipient. However, providers may not refuse to provide services to a recipient solely for failure to make this copayment.

Recipients cannot be held responsible for copayment established by commercial health insurance carriers. Additional information about Medicaid copayment is available in Section V-E of Part A, the all-provider handbook.

M. Follow-up to Claim Submission

Claims Submission Deadline

The fiscal agent must receive all claims for services provided to eligible recipients within 365 days from the date of service. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Wisconsin Medicaid advises providers that the fiscal agent takes no further action on a denied claim until the information is corrected and the provider resubmits the claim for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information about:

- The Remittance and Status Report.
- Adjustments to paid claims.
- Return of overpayments.
- Duplicate payments.
- Denied claims.
- Good faith claims filing procedures.

M. Follow-up to Claim Submission (continued)

In cases where a tooth number is questioned by the fiscal agent and results in a claim denial, a pre-operative radiograph is required to be resubmitted with a new claim, which is reviewed by the dental consultant.

Refer to Section IX of Part A, the all-provider handbook, for exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals.

Section X of Part A, the all-provider handbook, also includes information related to appropriate claim follow-up procedures.

N. ClaimCheck® for Oral Surgery

Wisconsin Medicaid uses automated procedure coding review software (GMIS ClaimCheck®) to review claims submitted by oral surgeons billing for oral surgery services with CPT procedure codes. Insurance companies and other state Medicaid programs also use similar software. This enhanced claims processing system reflects and monitors current Medicaid reimbursement policy. The enhancement incorporates coding generally consistent with the CPT, although, it has been customized to reflect Wisconsin Medicaid reimbursement policies.

Only CPT codes are reviewed. Claims are reviewed for several categories of billing inconsistencies and errors. Reviews include the unbundling of procedure codes, separate billing for incidental or integral procedures, and billing mutually exclusive codes.

ClaimCheck® affects claims in any of the following ways:

- The claim may pass through unchanged.
- The procedure codes may be rebundled into one or more appropriate codes.
- One or more of the codes may be denied as incidental/integral or mutually exclusive (the remaining codes continue processing).

How ClaimCheck® Affects Billing Inconsistencies

Unbundling (Code Splitting)

Unbundling occurs when two or more CPT codes are used to describe a procedure that may be better described by a single, more comprehensive code. For example, ClaimCheck® will add the lengths of individual wound repairs on the same anatomical site. A wound repair of 2.5 cm or less (procedure code 12011) coupled with a wound repair of 5.1 cm to 7.5 cm (procedure code 12014) will be rebundled to procedure code 12015 - wound repair 7.6 cm to 12.5 cm.

GMIS ClaimCheck® considers the single, most appropriate code for reimbursement when unbundling is detected.

GMIS ClaimCheck® totals billed amounts for individual procedures. For example, if three procedures billed at $20, $25, and $30 are rebundled into a single procedure code, GMIS ClaimCheck® adds the three amounts and calculates the billed amount for the rebundled code at $75. However, Wisconsin Medicaid reimburses the provider either the lesser of the billed amount or the maximum allowable fee for that procedure code.

N. ClaimCheck® for Oral Surgery (continued)

Incidental/Integral Procedures

Incidental procedures are those performed at the same time as a more complex primary procedure. They require few additional oral surgeon resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of jaw joint cartilage (procedure code 21060) is incidental to the extensive jaw surgery (procedure code 21045).

Integral procedures are those performed as a part of a more complex primary procedure. For example, when a recipient undergoes a diagnostic arthroscopy of the temporomandibular joint (procedure code 29800) and a surgical arthrotomy of the same joint, the diagnostic procedure is considered integral to the performance of the arthrotomy. When a procedure is considered either incidental or integral to a more complex procedure, only the primary procedure is considered for payment.

Mutually Exclusive

Mutually exclusive procedures are those that are not usually performed at the same operative session on the same date of service. This also pertains to different procedure codes billed for the same type of procedure when only one of the codes should be billed. For example, if an oral surgeon bills a closed treatment of a palatal or maxillary fracture (LeFort I type) and an open treatment of the same fracture (procedure codes 21421 and 21422), one of the procedures will be found mutually exclusive to the other.

When ClaimCheck® finds two or more procedures mutually exclusive, only the code with the highest billed usual and customary charge is considered for reimbursement.

Periodic Review of Previously Submitted Claims

Periodically, the claims processing system reviews claims history to identify related procedures or separate claims that have been billed for services rendered by the same performing provider, to the same recipient, on the same date of service. These claims are reviewed to detect unbundling, mutually exclusive and incidental/integral coding errors. Providers will be notified by letter of these billing errors with a request for repayment.

Requesting Adjustments

Providers may request adjustments to paid claims by submitting an adjustment request form with documentation that explains why the procedure review should not be followed. Documentation might include operative reports, descriptions of special circumstances, or other information that justifies overruling the denial. Write “dental review requested” on the adjustment form. For the adjustment form and instructions, refer to Part A, the all-provider handbook, Appendices 27 and 27a.